MEDICAID DISABILITY APPLICATION

SHADED AREA TO BE COMPLETED BY WORKER			
Worker's Name	**Worker's Address**	**Worker's Phone #**	**Client ID#** **PACMIS CASE #**

The following sections to be completed by applicant or representative. Return completed form to the Worker/Address indicated above. If you need additional space, please attach a separate sheet.

1. Name _____ Social Security Number _____
   Birth Date _____ Phone Number _____
   Address _____ City _____ Zip _____

2. What is your disabling condition? (Describe the illness or injury.)
   _____
   _____

If the applicant is a child, please disregard the work section. **Use Section 12 for description of activities.**

3. When did your condition make you stop working? Month _____ Year _____
   _____

4. Work History - List the jobs you have had in the past 15 years. Use a continuation page if necessary.

JOB TITLE (List last job, next to last, and so on.)	NAME OR TYPE OF COMPANY	DATES WORKER (Month and Year)		DAYS PER WEEK
		FROM	TO	

5. Education - What is the highest school grade you completed and when. _____
   List any special training you have had (trade schools, technical courses, etc.) _____
   _____

6. Indicate the doctor who has the latest medical recors about your disabling condition.

NAME	ADDRESS	PHONE NUMBER
HOW OFTEN DO YOU SEE THIS DOCTOR	DATE YOU FIRST SAW THIS DOCTOR	DATE YOU LAST SAW THIS DOCTOR
REASON FOR VISITS (Show illness or injury for which you had an examination or treatment.)		

7. List any other doctors you have seen in the last 12 months.

NAME	ADDRESS	PHONE NUMBER
HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE YOU FIRST SAW THIS DOCTOR?	DATE YOU LAST SAW THIS DOCTOR
REASON FOR VISITS - (Show illness or injury for which you had an examination or treatment.)		

NAME	ADDRESS	PHONE NUMBER
HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE YOU FIRST SAW THIS DOCTOR?	DATE YOU LAST SAW THIS DOCTOR
REASON FOR VISITS - (Show illness or injury for which you had an examination or treatment.)		

8. List the hospitals where you have been treated in the last 12 months. .

NAME OF HOSPITAL OR CLINIC		ADDRESS
DATES OF ADMISSIONS	DATES OF DISCHARGES	DATES OF OUTPATIENT VISITS
REASON FOR VISITS - (Show illness or injury for which you had an examination or treatment.)		

NAME OF HOSPITAL OR CLINIC		ADDRESS
DATES OF ADMISSIONS	DATES OF DISCHARGES	DATES OF OUTPATIENT VISITS
REASON FOR VISITS - (Show illness or injury for which you had an examination or treatment.)		

9. Other agencies/programs you are involved in (Voc Rehab, Mental Health, VA, SSI, etc)

NAME OF AGENCY	**ADDRESS**	**DATE OF VISITS**

10. Have you had any of the following tests or procedures in the last year?

Name of Test	Check Box	When	Where
Electrocardiogram and/or exercise test	☐ Yes ☐ No		
X-Rays (indicate areas -chest, knee, etc.)	☐ Yes ☐ No		
Breathing Tests	☐ Yes ☐ No		
Blood Tests	☐ Yes ☐ No		
Surgery/biopsy (Describe)	☐ Yes ☐ No		
Other (Specify)	☐ Yes ☐ No		

If more space is needed to list other doctors, hospitals, agencies, etc., use a separate sheet.

INFORMATION ABOUT YOUR ACTIVITIES

11. Describe your current activities in the following areas. How much/often do you perform them?

Household maintenance: (For example: cooking, cleaning, shopping, paying bills and performing odd jobs around the house as well as any other similar activities.)
Social Contacts: (For example: visits with friends, relatives, neighbors, attending church, parties, etc.)
Recreational activities and hobbies: (For example: hunting, fishing, bowling, hiking, playing musical instruments, eating out, playing cards or board games, going to movies or watching television, etc.)
Other: (For example: driving cars, riding with others, riding the bus, riding bicycles, walking, etc.)

12. Compare your child's activities and abilities to other children the same age._____

_____

_____

_____

_____

_____

_____

_____

Completed by: _____ **Date:** _____

Signature

If completed by other than applicant, indicate relationship to applicant: _____

STOP

THIS PAGE FOR WORKER USE ONLY

OBSERVATIONS: Check any areas where difficulties were observed.

Reading	☐ Yes ☐ No	Seeing	☐ Yes ☐ No
Writing	☐ Yes ☐ No	Using hands	☐ Yes ☐ No
Hearing	☐ Yes ☐ No	Sitting	☐ Yes ☐ No
Understanding	☐ Yes ☐ No	Walking	☐ Yes ☐ No
Answering	☐ Yes ☐ No	Balance	☐ Yes ☐ No
Breathing	☐ Yes ☐ No	Other (specify): _____	

If any of the above items were checked "yes", describe in detail the difficulty observed.

- Does the client speak English? ☐ Yes ☐ No If no, what language is spoken? _____
- What are the client's current living arrangements, i.e. lives independently in a home apartment, etc, or requires assistance, lives with relative, friend, in a group home, etc.?

  _____

  _____
- Please describe the client's ability to function, i.e. ability to understand, remember and follow instructions. Can he/she care for personal needs, shop, manage funds, pay bills? Can he/she interact successfully with others?

  _____

  _____
- If the client needs assistance in processing the claim or obtaining additional information, show name, address, phone number and relationship of interested party. _____

  _____

Completed by: _____ Date _____

Signature

Title: _____ **Office Code** _____